Guide to Checking Insurance Benefits

We encourage all families to explore their therapy benefits. A quick call to your insurance can help you plan your child's care and avoid any surprise bills. Here is how:

1. Call the customer service number on the back of your insurance card.
2. Ask the following **bold** questions to obtain your benefits for Occupational/Speech Therapy. Sometimes these services are called outpatient rehabilitation. The location of service is outpatient clinic.

Is my plan in-network with Whole Circle Pediatric Therapy?

_____ Yes

_____ No; Are out-of-network benefits available in my plan? _____ Yes _____ No

Does my plan require a physician's referral for Occupational/Speech Therapy?

_____ Yes _____ No

What is the individual deductible for my child? Total: $_____ Met: $_____

Does the deductible apply for Occupational/Speech Therapy services?

_____ Yes _____ No

What is the total out of pocket maximum (OOP)? Total: $_____ Met: $_____

Once the deductible is met, do I have a copay or coinsurance?

Copay Amount: $_____ ***OR*** Coinsurance percentage: _____%

Is there a maximum benefit limit?

_____ Yes _____ visits or dollars per year _____ visits or dollars remaining.

_____ No

Can additional visits be authorized after the maximum benefit limit is met?

_____ Yes, the procedure for requesting additional visits is: _____

_____ No

When is the plan reset?

_____ Calendar year

_____ Plan Year: _____/_____/_____

Does my plan require prior authorization for my child's therapy discipline (Occupational or Speech Therapy)? If the answer is yes, Whole Circle will submit the authorization request on your behalf. Please be aware that authorizations may impact the scheduling process.

_____ Yes, which discipline(s)? _____

_____ No

Do not hesitate to ask your insurance provider any questions for better clarification regarding your coverage. They are the best equipped to answer questions specific to your plan.

Definitions:

Allowed Amount: Dollar amount at which the insurance company values each service billed.

Contractual Adjustment: The difference between the allowed amount and the billed amount that is not considered payable by the insurance.

Deductible: Dollar amount that the patient must pay out of pocket before insurance will pay any part of claims. The billed amount, or the allowed amount set by the insurance, will be applied per visit until the deductible is satisfied.

Out of Pocket Maximum: Dollar amount the patient must pay before insurance covers claims at 100% and the patient no longer has financial responsibility for the year.

Coinsurance: Percentage of billed amount (usually minus your insurance's contractual adjustments) that will be billed to the patient's responsibility.

Copay: Flat dollar amount that must be paid at the time of service. Your insurance will then process the billed amount minus the copay and contractual adjustments.

Benefit Maximum: The maximum number of visits or billed dollar amount that the insurance will consider for payment each plan year. Some plans allow additional visits to be covered beyond the benefit maximum with an authorization in place.

Authorization: an approval granted by an insurance company that is necessary to cover certain serves, medications, and medical equipment. Decisions are based on medial necessity.

Medical Necessity: Medical services proved by a licensed provider that are considered necessary to treat an illness or condition and conform to accepted standards of medical care. Services must be considered reasonable in terms of type, frequency, site, and duration.